CNIC Health Solutions
A Rocky Mountain Health Plans TPA

CLAIM FORM

TO BE COMPLETED FOR ALL MEMBER SUBMITTED CLAIMS. ATTACH RECEIPTS AND ITEMIZED BILLS TO THIS FORM AND FORWARD TO THE ADDRESS SHOWN ON THE REVERSE SIDE OF THE ID CARD

Employee Information: Complete in all cases

Last Name	First Name	M.I.	Enrollee Number	Group Number

Street Address	City	State	Zip Code

Plan Sponsor (Employer)	Date of Birth (MM/DD/YY)	Gender	Marital Status
	/ /	Male Female	Married Single Divorced Widowed

Dependent Information: Complete if dependent is the patient.

Name	Date of Birth (MM/DD/YY)	Relationship	Gender
	/ /	Child Other Spouse	Male Female

Other Insurance Information: Complete in all cases

Name of Spouse	Date of Birth (MM/DD/YY)	Social Security Number
	/ /	/ /

Is Spouse Employed?	Is Spouse covered through an employer plan?	Carrier's Name/Phone/Policy #
Yes Employer Name No	Yes Are dependents covered? No Yes No	

Is patient covered under any other medical plan not described above?	Is patient eligible for Medicare	Was the claim the result of an accidental injury?
Yes (Please describe below) No	Part A (hospitalization) Yes No Part B (Physician Services) Yes No	Yes At work Yes In auto Yes No No No Please describe in detail in box below.

Child Information: Complete if the patient is a dependent child.

Is the child employed?	Is the child a full time student?	Marital Status
Yes Full-time Part-time No	Yes Name of School No	Married Single Divorced Widowed

I certify that all information above is true to the best of my knowledge.	I authorize the release of any medical or other information necessary to process this claim.
Employee Signature and date:	Employee Signature and date:
Spouse Signature and date, if spouse is patient:	Spouse Signature and date, if spouse is patient:

AUTHORIZATION FOR DIRECT PAYMENT: Sign **ONLY** if you want payment to go to the provider of service instead of coming directly to you.

Employee Signature and date: